		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040543

Facility Name: Tabor Hills Health Care Facility

Address: 1347 Crystal Court (Number) Naperville (City) 60563 (Zip Code)

County: DuPage

Telephone Number: (630) 778-6677 **Fax #** (630) 778-6680

IDPA ID Number: 363867476001

Date of Initial License for Current Owners: 04/28/95

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Mr. Charles Fischer **Telephone Number:** (312) 634-4580
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/00 to 9/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	64	Skilled (SNF)	64	23,360	1
2		Skilled Pediatric (SNF/PED)			2
3	147	Intermediate (ICF)	147	53,655	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,015	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	148	528	3,614	4,290	8
9	SNF/PED					9
10	ICF	28,653	38,690		67,343	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,801	39,218	3,614	71,633	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.01%

D. How many bed-hold days during this year were paid by Public Aid? 59 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 04/28/95

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 04/28/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 17 and days of care provided 3,614

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 09/30/01 Fiscal Year: 09/30/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 **Report Period Beginning:** 10/1/00 **Ending:** 9/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	348,385	23,073	9,439	380,897		380,897		380,897			1
2	Food Purchase		318,625		318,625		318,625		318,625			2
3	Housekeeping	271,781	76,425	15,830	364,036		364,036		364,036			3
4	Laundry	107,222	70,944	3,097	181,263		181,263		181,263			4
5	Heat and Other Utilities			230,556	230,556		230,556		230,556			5
6	Maintenance	131,156	31,485	155,536	318,177		318,177		318,177			6
7	Other (specify):*											7
8	**TOTAL General Services**	858,544	520,552	414,458	1,793,554		1,793,554		1,793,554			8
	B. Health Care and Programs											
9	Medical Director			29,540	29,540		29,540		29,540			9
10	Nursing and Medical Records	3,532,821	227,588	795,103	4,555,512		4,555,512		4,555,512			10
10a	Therapy	188,206	56,042	118,847	363,095		363,095		363,095			10a
11	Activities	121,763	4,754	6,361	132,878		132,878		132,878			11
12	Social Services	105,856	313	5,909	112,078		112,078		112,078			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,948,646	288,697	955,760	5,193,103		5,193,103		5,193,103			16
	C. General Administration											
17	Administrative	159,549			159,549		159,549		159,549			17
18	Directors Fees											18
19	Professional Services			185,833	185,833		185,833	(30,571)	155,262			19
20	Dues, Fees, Subscriptions & Promotions			57,352	57,352		57,352		57,352			20
21	Clerical & General Office Expenses	363,532	60,180	102,487	526,199		526,199	(7,813)	518,386			21
22	Employee Benefits & Payroll Taxes			826,313	826,313		826,313		826,313			22
23	Inservice Training & Education			535	535		535		535			23
24	Travel and Seminar			13,947	13,947		13,947	(1,101)	12,846			24
25	Other Admin. Staff Transportation			9,430	9,430		9,430		9,430			25
26	Insurance-Prop.Liab.Malpractice			131,354	131,354		131,354		131,354			26
27	Other (specify):*											27
28	**TOTAL General Administration**	523,081	60,180	1,327,251	1,910,512		1,910,512	(39,485)	1,871,027			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,330,271	869,429	2,697,469	8,897,169		8,897,169	(39,485)	8,857,684			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Tabor Hills Health Care Facility #0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			477,402	477,402		477,402	(2,705)	474,697			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			469,648	469,648		469,648	(68)	469,580			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			947,050	947,050		947,050	(2,773)	944,277			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		104,815		104,815		104,815		104,815			39
40	Barber and Beauty Shops			33,446	33,446		33,446		33,446			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,523	115,523		115,523		115,523			42
43	Other (specify):* **Nonallowable costs**		12,388	163,970	176,358		176,358	(176,358)				43
44	**TOTAL Special Cost Centers**		117,203	312,939	430,142		430,142	(176,358)	253,784			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,330,271	986,632	3,957,458	10,274,361		10,274,361	(218,616)	10,055,745			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,705)	30		9
10	Interest and Other Investment Income	(68)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,000)	19		17
18	Fines and Penalties	(13,570)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,175)	43		24
25	Fund Raising, Advertising and Promotional	(16,685)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	(146,413)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (218,616)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (218,616)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility

ID# 0040543

Report Period Beginning: 10/1/00

Ending: 9/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Tabor Hills Health Care Facility
IDPH Facility # 0040543
9/30/2001

Schedule 5A

Schedule VI. Part A - Adjustment Detail, Line 29

Non-allowable expenses	Amount	Reference
Disallow Residents' Personal Expenses	(13,584)	43
Disallow Out of State Travel and Seminar	(1,101)	24
Out-of-period Legal Fees	(24,571)	19
Residents' Clothing	(1,128)	43
Laboratory Expenses	(11,260)	43
Radiology Expenses	(86,956)	43
Miscellaneous expense	(7,813)	21
Total	(146,413)	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 **Report Period Beginning:** 10/1/00 **Ending:** 9/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,000)	0	0	0	0	0	0	0	0	0	0	(6,000)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 **Report Period Beginning:** 10/1/00 **Ending:** 9/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,705)	0	0	0	0	0	0	0	0	0	0	(2,705)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(68)	0	0	0	0	0	0	0	0	0	0	(68)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,773)	0	0	0	0	0	0	0	0	0	0	(2,773)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(63,430)	0	0	0	0	0	0	0	0	0	0	(63,430)	43
44	**TOTAL Special Cost Centers**	(63,430)	0	0	0	0	0	0	0	0	0	0	(63,430)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(72,203)	0	0	0	0	0	0	0	0	0	0	(72,203)	45

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Bohemian Home for the Aged	100.00%			Bohemian Home for the Aged	Naperville	Townhomes
See attached Schedule 6A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V				N/A				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3		N/A									3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4					N/A					4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Norwest Bank of Wisconsin		x	Mortgage	Principal and	3/31/98	$ 8,095,000	$ 7,804,350	11/2024	Varies	$ 448,272	1
2					Interest due							2
3					Semi-annually							3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 8,095,000	$ 7,804,350			$ 448,272	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(68)	12
13								Amortization of Loan Fees			21,376	13
14	TOTAL Non-Facility Related						$	$			$ 21,308	14
15	TOTALS (line 9+line14)						$ 8,095,000	$ 7,804,350			$ 469,580	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Tabor Hills Health Care Facility COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0040543

CONTACT PERSON REGARDING THIS REPORT Ms. Gloria Pindiak

TELEPHONE (630) 778-6677 FAX #: (630) 778-6680

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,980 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Bohemian Home for the Aged d/b/a Tabor Hills Adult Community provides housing to seniors through an adult living community.
There are 104 townhomes and a total of 1,267,596 square feet of land.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	264,519	1995	$ 574,693	1
2					2
3	TOTALS	264,519		$ 574,693	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	211		1995	1995	$ 10,039,753	$ 249,931	40	$ 250,994	$ 1,063	$ 1,630,924	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land improvements			1995	36,958	2,751	15	2,464	(287)	16,015	9
10	Improvements			1995	1,421		40	36	36	363	10
11	Sign			1997	500	13	40	13		58	11
12	Electric			1996	656	16	40	16		72	12
13	Humidistats			1996	1,378	34	40	34		153	13
14	Door alarm			1996	854	22	40	22		99	14
15	Plumbing			1996	1,050	26	40	26		117	15
16	Install lights, water heater			1997	2,345	58	40	58		261	16
17	Pipe			1997	618	16	40	16		72	17
18	Electric			1997	3,121	78	40	78		351	18
19	Signs & outlets			1997	2,504	62	40	62		279	19
20	Wall hugging overbed lights			1997	27,302	671	40	671		3,037	20
21	Air compressor			1997	2,078	52	40	52		234	21
22	Roof repair			1997	3,154	78	40	78		351	22
23	Deco-gard products			1997	738	18	40	18		82	23
24	Shelving units			1998	2,317	58	40	58		203	24
25	Chimney cap			1998	945	95	40	24	(71)	84	25
26	Access door			1998	2,061	52	40	52		182	26
27	Bumper guards			1998	3,687	92	40	92		322	27
28	Land improvement - survey			1998	800		10	80	80	280	28
29	Carpeting			1999	67,303	6,730	10	6,730		16,265	29
30	Miniblinds			1999	3,501	350	10	350		729	30
31	Vertical blinds			1999	1,974	197	10	197		559	31
32	Swingmaster door			1999	2,357	236	10	236		668	32
33	Security lock			1999	2,779	278	10	278		718	33
34	WanderGuard code alert system			1999	16,182		10	1,618	1,618	4,045	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	2000	$ 225	$ 22	10	$ 22	$	$ 25	37
38	Railing & Bumper	2000	3,275	81	40	81		128	38
39	Carpeting	2000	41,999	3,850	10	3,850		3,850	39
40	Tile	2001	6,493	135	40	135		135	40
41	Courtyard improvements	2001	15,673	33	40	33		33	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,296,001	$ 266,035		$ 268,474	$ 2,439	$ 1,680,694	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,704,809	$ 182,211	$ 180,942	$ (1,269)	5-10	$ 1,087,023	71
72	Current Year Purchases	74,708	5,326	5,326		5-10	5,326	72
73	Fully Depreciated Assets	18,703				5	18,703	73
74								74
75	TOTALS	$ 1,798,220	$ 187,537	$ 186,268	$ (1,269)		$ 1,111,052	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See Attached Schedule 13A			$ 130,845	$ 23,830	$ 19,955	$ (3,875)	5	$ 77,463	76
77										77
78										78
79										79
80	TOTALS			$ 130,845	$ 23,830	$ 19,955	$ (3,875)		$ 77,463	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 12,799,759	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 477,402	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 474,697	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,705)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,869,209	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-care related Bus	$ 38,750	$ 3,875	$ 38,750	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 38,750	$ 3,875	$ 38,750	91

G. Construction-in-Progress

	Description	Cost	
92	Dining Room Expansion	$ 38,606	92
93			93
94			94
95		$ 38,606	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Tabor Hills Health Care Facility
IDPH Facility # 0040543
9/30/2001

Schedule 13A

Schedule XI - D Vehicle Depreciation

Use	Model, Make and Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
Medical Transportation	1988 Ford Van	1988	23,216				5	23,216
Facility Use	2001 Chrysler Van	2001	31,409	4,711	4,711		5	4,711
Non-care related	Bus			3,875	-	(3,875.00)	5	
Administrator Use	2000 Chrysler Van	2000	31,930	6,386	6,386	-	5	9,675
Facility Use	1997 Ford Eldorado Bus	1997	44,290	8,858	8,858	-	5	39,861
			130,845	23,830	19,955	(3,875)		77,463

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C1	1674 hrs	$ 41,401		$	$	1,674	$ 41,401	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,336	21,975		1,336	21,975	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C1 & C2	3866 hrs	96,657			2,636	3,866	99,293	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				104,815		104,815	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	L10A, C2					37,740		37,740	13
14	TOTAL			$ 138,058	1,336	$ 21,975	$ 145,191	6,876	$ 305,224	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (76,911)	$ (76,911)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 112,000)	1,165,546	1,165,546	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	203,149	203,149	6
7	Other Prepaid Expenses	43,182	43,182	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,334,966	$ 1,334,966	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	574,693	574,693	13
14	Buildings, at Historical Cost	9,997,265	10,039,753	14
15	Leasehold Improvements, at Historical Cost	295,052	256,248	15
16	Equipment, at Historical Cost	1,978,075	1,929,065	16
17	Accumulated Depreciation (book methods)	(2,909,553)	(2,869,209)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp See attch. Sch17A	310,674	310,674	22
23	Other(specify): Prepaid pension cost	400,932	400,932	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,647,138	$ 10,642,156	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,982,104	$ 11,977,122	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 97,890	$ 97,890	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	166,050	166,050	29
30	Accrued Salaries Payable	252,549	252,549	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	169,643	169,643	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	111,057	111,057	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 797,189	$ 797,189	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,638,300	7,638,300	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,638,300	$ 7,638,300	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,435,489	$ 8,435,489	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,546,615	$ 3,541,633	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,982,104	$ 11,977,122	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Tabor Hills Health Care Facility
IDPH Facility # 0040543
9/30/2001

Schedule 17A

XV. Balance Sheet

B. Long term Assets
Line 22

		Operating	After Consolidation
Finance Fees		272,068	272,068
Construction in Progress		38,606	38,606
	Total	310,674	310,674

C. Current Liabilities
Line 36

		Operating	After Consolidation
Resident Credit Balances		99,718	99,718
Wage Assignments		90	90
Accrued Expenses		11,249	11,249
	Total	111,057	111,057

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,836,972	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,836,972	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	556,706	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 556,706	17
	B. Transfers (Itemize):		
18			18
19			19
20	**Interorganization transfers**	(847,063)	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (847,063)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,546,615	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,303,886	1
2	Discounts and Allowances for all Levels	(706,708)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,597,178	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	363,852	6
7	Oxygen	67,910	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 431,762	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	37,156	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	5,742	15
16	Rental of Facility Space		16
17	Sale of Drugs	106,540	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,535	19
20	Radiology and X-Ray	100,416	20
21	Other Medical Services	467,419	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 726,808	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	68	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 68	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bedhold Revenue	67,321	28
28a	Miscellaneous and Resident Income (Offset)	7,930	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 75,251	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,831,067	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,793,554	31
32	Health Care	5,193,103	32
33	General Administration	1,910,512	33
	B. Capital Expense		
34	Ownership	947,050	34
	C. Ancillary Expense		
35	Special Cost Centers	314,619	35
36	Provider Participation Fee	115,523	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,274,361	40
41	**Income before Income Taxes (line 30 minus line 40)****	556,706	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 556,706	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**
This facility is a not-for-profit organization. It is not subject to income taxes.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,998	2,086	$ 59,268	$ 28.41	1
2	Assistant Director of Nursing	1,809	2,076	49,528	23.86	2
3	Registered Nurses	51,993	55,385	1,224,735	22.11	3
4	Licensed Practical Nurses	19,943	21,429	396,451	18.50	4
5	Nurse Aides & Orderlies	113,379	121,778	1,492,907	12.26	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,989	5,540	138,058	24.92	7
8	Rehab/Therapy Aides	7,917	8,572	114,212	13.32	8
9	Activity Director	1,933	2,290	26,206	11.44	9
10	Activity Assistants	15,923	17,545	95,557	5.45	10
11	Social Service Workers	8,043	8,828	105,856	11.99	11
12	Dietician	1,998	2,155	39,479	18.32	12
13	Food Service Supervisor	1,206	1,365	15,795	11.57	13
14	Head Cook	4,619	5,284	63,095	11.94	14
15	Cook Helpers/Assistants	25,404	27,042	222,901	8.24	15
16	Dishwashers	993	1,026	7,115	6.93	16
17	Maintenance Workers	6,618	7,159	131,156	18.32	17
18	Housekeepers	33,454	37,043	271,781	7.34	18
19	Laundry	12,849	14,123	107,222	7.59	19
20	Administrator	1,909	2,086	104,447	50.07	20
21	Assistant Administrator	1,902	2,086	55,102	26.42	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,848	27,065	363,532	13.43	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,335	4,775	59,797	12.52	31
32	Other Health Ca See att. Sch. 20A	10,183	10,889	186,071	17.09	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	358,245	387,627	$ 5,330,271 *	$ 13.75	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 9,439	L1, C3	35
36	Medical Director	Monthly	29,540	L9, C3	36
37	Medical Records Consultant	Monthly	3,024	L10, C3	37
38	Nurse Consultant	Monthly	17,714	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	16	866	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	73	3,987	L11, C3	44
45	Social Service Consultant	71	5,909	L12, C3	45
46	Other(specify)				46
47	Alzheimers Consultant	Monthly	842	L10, C3	47
48					48
49	TOTAL (lines 35 - 48)	160	$ 71,321		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,050	$ 231,022	L10, C3	50
51	Licensed Practical Nurses	1,108	38,948	L10, C3	51
52	Nurse Aides	25,613	503,553	L10, C3	52
53	TOTAL (lines 50 - 52)	31,771	$ 773,523		53

Tabor Hills Health Care Facility
IDPH Facility # 0040543
9/30/2001

Schedule 20A

Page 20 - Schedule XVIII. A. Staffing and Salary Costs
Line 33 - Other

Description	Hours Worked	Hours Paid	Wages	Average Wages
Ward Clerk	4,506	4,806	61,893	12.88
MDS Care Plan Coordinator	3,743	3,997	74,030	18.52
Rehabilitation Coordinator	1,934	2,086	50,148	24.04
Total	10,183	10,889	186,071	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gloria Pindiak	Administrator	0%	$ 104,447
Clara Leonard	Asst. Administrator	0%	55,102
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 159,549

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
See Attached Schedule 21A		185,833
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 185,833

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 134,997
Unemployment Compensation Insurance	1,844
FICA Taxes	395,463
Employee Health Insurance	190,689
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	2,839
Employee Appreciation	15,225
Employee Physicals	5,965
Employee Pension	29,989
Life/Disability Insurance	22,008
401K Expense	18,075
Other Employee Benefits	9,219
TOTAL (agree to Schedule V, line 22, col.8)	$ 826,313

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	39,138
Health Care Worker Background Check	
(Indicate # of checks performed 128)	1,536
Life Services Network of Illinois	9,998
Licenses, Permits, & Inspections	1,242
Subscriptions	3,752
Membership Dues	1,686
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 57,352

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,509
Seminar Expense	11,337
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,846

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Tabor Hills Health Care Facility
IDPH Facility # 0040543
9/30/2001

Schedule 21A

XIX. C. Support Schedules - Line 19

Vendor/Payee	Type	Total
Burke, Warren, Mackay & Sterritella	Legal	60,582
Maureen M. Thomas, Ltd.	Legal	100
Erickson, Papanek, Hanson, Peterson	Legal	3,707
Duane, Morris & Heckscher	Legal	16,945
Esquire Deposition Services - ECG	Legal	307
McCorkle Court Reporters, Inc.	Legal	2,872
Smith, Hemmesch, Burke & Brannigan	Legal	6,000
Ratish Kaura MDSC	Consulting	1,600
Burke & Raben Expense Reduction	Consulting	958
American Express Tax & Business Services, Inc.	Accounting and Tax	4,963
Altschuler, Melvoin & Glasser LLP	Audit and Accounting	70,348
HDSI	Computer Services	7,465
Vopenka & Associates	Computer Services	8,185
Medical Comm Software, Inc.	Computer Services	764
Med E America	Computer Services	175
America Online	Computer Services	248
Netsource Communications, Inc.	Computer Services	120
Accu-Med Services	Computer Services	444
Orion Computer Technology	Computer Services	50
Agrees to Schedule V, Line 19, Column 3		185,833
Out-of-period legal fees		(24,571)
Nonallowable legal fees		(6,000)
Agrees to Schedule V, Line 19, Column 8		155,262

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 Report Period Beginning: 10/1/00 Ending: 9/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7								N/A					
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Tabor Hills Health Care Facility # 0040543 **Report Period Beginning:** 10/1/00 **Ending:** 9/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network of Illinois - $9,998**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **87,417** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **115,523**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0 %**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: **Altschuler, Melvoin & Glasser LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	348,385	23,073	9,439	380,897	0	380,897	0	380,897
2. Food Purchase	0	318,625	0	318,625	0	318,625	0	318,625
3. Housekeeping	271,781	76,425	15,830	364,036	0	364,036	0	364,036
4. Laundry	107,222	70,944	3,097	181,263	0	181,263	0	181,263
5. Heat and Other Utilities	0	0	230,556	230,556	0	230,556	0	230,556
6. Maintenance	131,156	31,485	155,536	318,177	0	318,177	0	318,177
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	858,544	520,552	414,458	1,793,554	0	1,793,554	0	1,793,554
9. Medical Director	0	0	29,540	29,540	0	29,540	0	29,540
10. Nursing & Medical Records	3,532,821	227,588	795,103	4,555,512	0	4,555,512	0	4,555,512
10a. Therapy	188,206	56,042	118,847	363,095	0	363,095	0	363,095
11. Activities	121,763	4,754	6,361	132,878	0	132,878	0	132,878
12. Social Services	105,856	313	5,909	112,078	0	112,078	0	112,078
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,948,646	288,697	955,760	5,193,103	0	5,193,103	0	5,193,103
17. Administrative	159,549	0	0	159,549	0	159,549	0	159,549
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	185,833	185,833	0	185,833	-30,571	155,262
20. Fees, Subscriptions & Promotion	0	0	57,352	57,352	0	57,352	0	57,352
21. Clerical & General Office	363,532	60,180	102,487	526,199	0	526,199	-7,813	518,386
22. Employee Benefits & Payroll	0	0	826,313	826,313	0	826,313	0	826,313
23. Inservice Training & Education	0	0	535	535	0	535	0	535
24. Travel and Seminar	0	0	13,947	13,947	0	13,947	-1,101	12,846
25. Other Admin. Staff Trans	0	0	9,430	9,430	0	9,430	0	9,430
26. Insurance-Prop.Liab.Malpractice	0	0	131,354	131,354	0	131,354	0	131,354
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	523,081	60,180	1,327,251	1,910,512	0	1,910,512	-39,485	1,871,027
29. Total General Administrative	5,330,271	869,429	2,697,469	8,897,169	0	8,897,169	-39,485	8,857,684
30. Depreciation	0	0	477,402	477,402	0	477,402	-2,705	474,697
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	469,648	469,648	0	469,648	-68	469,580
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	947,050	947,050	0	947,050	-2,773	944,277
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	104,815	0	104,815	0	104,815	0	104,815
40. Barber and Beauty Shop	0	0	33,446	33,446	0	33,446	0	33,446
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	115,523	115,523	0	115,523	0	115,523
43. Other (specify):*	0	12,388	163,970	176,358	0	176,358	-176,358	0
44. Total Special Cost Ce	0	117,203	312,939	430,142	0	430,142	-176,358	253,784
45. Grand Total	5,330,271	986,632	3,957,458	########	0	########	-218,616	########

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-76,911	-76,911
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,165,546	1,165,546
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	203,149	203,149
7. Other Prepaid Expenses	43,182	43,182
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,334,966	1,334,966
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	574,693	574,693
14. Buildings, at Historical Cost	9,997,265	10,039,753
15. Leasehold Improvements, Historical Cost	295,052	256,248
16. Equipment, at Historical Cost	1,978,075	1,929,065
17. Accumulated Depreciation (book methods)	-2,909,553	-2,869,209
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	310,674	310,674
23. other (specify):	400,932	400,932
24. Total Long-Term Assets	10,647,138	10,642,156
25. Total Assets	11,982,104	11,977,122
CURRENT LIABILITIES		
26. Accounts Payable	97,890	97,890
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	166,050	166,050
30. Accrued Salaries Payable	252,549	252,549
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	169,643	169,643
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	111,057	111,057
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	797,189	797,189
LONG TERM LIABILITES		
39.Long-Term Notes Payable	7,638,300	7,638,300
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	7,638,300	7,638,300
46.Total Liabilities	8,435,489	8,435,489
47.Total Equity	3,546,615	3,541,633
48.Total Liabilities and Equity	11,982,104	11,977,122

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,303,886
2. Discounts and Allowances for all Levels	-706,708
Subtotal - Inpatient Care	9,597,178
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	363,852
7. Oxygen	67,910
Subtotal - Anciliary Revenue	431,762
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	37,156
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	5,742
16. Rental of Facility Space	0
17. Sale of Drugs	106,540
18. Sale of Supplies to Non-Patients	0
19. Laboratory	9,535
20. Radiologyand X-Ray	100,416
21. Other Medical Services	467,419
22. Laundry	0
Subtotal - Other Operating Revenue	726,808
24. Contributions	0
25. Interest and Other Investments Income	68
Subtotal - Non-Operating Revenue	68
27. Other Revenue (specify):	67,321
28. Other Revenue (specify):	7930
Subtotal - Other Revenue	75,251
30. Total Revenue	10,831,067
31. General Services	1,793,554
32. Health Care	5,193,103
33. General Administration	1,910,512
34. Ownership	947,050
35. Special Cost Centers	314,619
35. Provider Participation Fee	115,523
37. Other	0
40. Total Expenses	10,274,361
41. Income Before Income Taxes	556,706
42. Income Taxes	0
43. Net Income or Loss for the Year	556,706

Page

1

2
3
4
5
6
7
8
9
10 Attachment of Real Estate Bill and fill out form

11
12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
13
14
15
16
17
18
19 The bottom right side of page under **, you must write in any comments
20
21
22
23

RECONCILIATION REPORT **Tabor Hills Health Care** **04:21 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-218,616	equal to	-218,616	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	469,580	equal to	469,580	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	474,697	equal to	474,697	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	138,058	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	162,669	equal to	363,095	-200,426	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	145,191	equal to	160,857	-15,666	FAILED	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,793,554	equal to	1,793,554	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	5,193,103	equal to	5,193,103	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,910,512	equal to	1,910,512	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	947,050	equal to	947,050	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	314,619	equal to	314,619	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	115,523	equal to	115,523	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,282,686	equal to	3,532,821	-250,135	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	138,058	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	121,763	equal to	121,763	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	105,856	equal to	105,856	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	348,385	equal to	348,385	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	131,156	equal to	131,156	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	271,781	equal to	271,781	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	107,222	equal to	107,222	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	159,549	equal to	159,549	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	363,532	equal to	363,532	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,330,271	equal to	5,330,271	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	9,439	< or = to	9,439	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	29,540	< or = to	29,540	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	794,261	< or = to	795,103	-842	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,987	< or = to	6,361	-2,374	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	5,909	< or = to	5,909	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	159,549	equal to	159,549	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	185,833	equal to	185,833	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	826,313	equal to	826,313	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	57,352	equal to	57,352	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	12,846	equal to	12,846	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	115,523	equal to	115,523	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	3,614	equal to	3,614	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	7,804,350	equal to	7,804,350	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	574,693	equal to	574,693	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	10,296,001	equal to	10,296,001	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,929,065	equal to	1,929,065	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	2,869,209	equal to	2,869,209	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,546,615	equal to	3,546,615	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	556,706	equal to	556,706	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	11,982,104	equal to	11,982,104	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1